Annual Report to

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

on

DEATHS REPORTED AND FACILITY COMPLIANCE WITH LAWS, RULES, AND REGULATIONS GOVERNING PHYSICAL RESTRAINTS AND SECLUSION

as required by SL 2000-129, Section 3(b), 5(b) and 6(b)
and as amended by SL 2003-58, Sections 1-4, and SL 2009-462, Section 1(e)

Submitted by
North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
and Division of Health Services Regulation

October 1, 2010

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EXECUTIVE SUMMARY

State law requires the Department of Health and Human Services (DHHS) to provide annual reports to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services on consumer deaths related to the use of physical restraint, physical hold, and seclusion, and compliance with policies and procedures governing the use of these restrictive interventions. The introduction to this report includes a brief summary of those reporting requirements. The data in this report is for State Fiscal Year (SFY) 2009-2010, which covers the period July 1, 2009 through June 30, 2010.

DEATHS RELATED TO PHYSICAL RESTRAINT, PHYSICAL HOLD, AND SECLUSION

In North Carolina, deaths are reported to DHHS by private licensed, private unlicensed, and state-operated facilities. The reporting requirements differ by type of facility. The data reported here include deaths required by state law to be reported: (a) occurred within seven days after the use of physical restraint, physical hold, or seclusion; or (b) resulted from violence, accident, suicide, or homicide. Table A, on page 5, provides a summary of the number of deaths reported, investigated, and found to be related to the use of physical restraint, physical hold, or seclusion.

A total of 205 deaths were reported: 96 by private licensed facilities, 97 by private unlicensed facilities, and 12 by state-operated facilities. Of the 205 deaths reported, all were screened, 164 (80%) were investigated, and none were found to be related to the use of physical restraint, physical hold, or seclusion.

FACILITY COMPLIANCE WITH LAWS, RULES, AND REGULATIONS GOVERNING THE USE OF PHYSICAL RESTRAINT, PHYSICAL HOLD, AND SECLUSION

The compliance data summarized here was collected from facilities that received an on-site visit by Department staff for initial, renewal and change-of-ownership licensure surveys, follow-up visits, and complaint investigations. Not all facilities were reviewed. A total of 3,149 licensure surveys, 1,503 follow-up visits, and 1,117 complaint investigations were conducted during the year. An exact number of facilities reviewed can not be readily determined as some facilities may have had more than one type of review. Table B, on page 7, provides a summary of the number of citations issued to private licensed, private unlicensed, and state-operated facilities and examples of the most frequent and least frequent citations issued to each type of facility.

A total of 223 facilities -- 222 private licensed facilities, no private unlicensed facilities, and one state-operated facility -- were issued a total of 360 citations for non-compliance with one or more rules governing the use of physical restraint, physical hold, or seclusion. For those facilities that received one, citations covered a wide range of deficiencies from inadequate documentation and training to improper or inappropriate use of physical restraints. The largest number of citations issued involved deficiencies related to "training on alternatives to restrictive interventions" (147 or 41%), "training in seclusion, physical restraint and isolation time-out" (120 or 33%), and failure to use "least restrictive alternative" (20 or 6%). These citations accounted for 80% of the total issued.

INTRODUCTION

Section 3(b), 5(b) and 6(b) of Session Law 2000-129 (HB 1520), as amended by Sections 1-4 of Session Law 2003-58 (HB 80) and Section 1(e) of Session Law 2009-462 (HB 456), requires the Department of Health and Human Services to report annually on October 1 to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services on the following for the immediately preceding fiscal year:

- The total number of facilities that reported deaths under G.S. 122C-31, G.S. 131D-10.6B, and G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to these statutes, and the number found by the investigation to be related to the use of restraint, physical hold, or seclusion.
- The level of compliance of certain facilities with applicable State and federal laws, rules, and regulations governing the use of restraints, physical hold, and seclusion. The information shall include areas of highest and lowest levels of compliance.

The facilities covered by these statutes are organized by this report into three groups -- private licensed facilities, private unlicensed facilities, and state-operated facilities.

The private licensed facilities include:

- Assisted Living Facilities
- Intermediate Care Facilities for Mental Retardation (ICF/MR)
- Group Homes, Day Treatment and Outpatient Treatment Programs
- Psychiatric Hospitals, Hospitals with Acute Care Psychiatric Units, and Psychiatric Residential Treatment Facilities (PRTFs)

The private unlicensed facilities include:

- Periodic service providers
- Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MR/DD) providers

The state-operated facilities include:

- Alcohol and Drug Abuse Treatment Centers (ADATCs)
- Developmental Centers (ICF/MR)
- Neuro-Medical Treatment Centers
- Psychiatric Hospitals
- Residential Programs for Children

This report covers **SFY 2009-2010**, the period **July 1, 2009 through June 30, 2010**. The report is organized into two sections (Parts A and B) and includes two Appendices (A and B).

- Part A provides summary data on deaths reported by these facilities and investigated by the Department.
- Part B provides summary data on deficiencies related to the use of physical restraints, physical hold, and seclusion compiled from monitoring reports, surveys and investigations conducted by Department staff.
- The Appendices contain tables that provide the information from Parts A and B by licensure or facility type and by county and facility name.

PART A. DEATHS REPORTED AND INVESTIGATED

Session Laws 2000-129, 2003-58 and 2009-462 amended G.S. 122C-31, 131D-10.6B and 131D-34.1 by requiring certain facilities to notify the North Carolina Department of Health and Human Services of any death of a consumer:

- Occurring within seven days of use of physical restraint or physical hold; or
- Resulting from violence, accident, suicide or homicide.

North Carolina Administrative Code 10A NCAC 26C .0300, 10A NCAC 13F .1207 and .1208, 10A NCAC 13G .1208 and .1209, and 10A NCAC 13H .1902 and .1903 implement the death reporting requirements of these laws and provide specific instructions for reporting deaths.

- **Facilities licensed** in accordance with G.S. 122C, Article 2, **State facilities** operating in accordance with G.S. 122C Article 4, Part 5, **facilities licensed** under G.S. 131D, and **inpatient psychiatric units** of hospitals licensed under G.S. 131E shall report client deaths to the **Division of Health Services Regulation** (DHSR).
- **Facilities not licensed** in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5 shall report client deaths to the **Division of Mental Health, Developmental Disabilities, and Substance Abuse Services** (DMH/DD/SAS).

North Carolina Administrative Code 10A NCAC 27G .0600, and Department policies and procedures require some types of facilities to report other deaths. For example:

- State-operated facilities report **all deaths** that occur in the facility, regardless of the manner of death. This includes deaths due to terminal illness, natural causes, and unknown causes.
- Private community-based providers report **deaths due to unknown causes** to DMH/DD/SAS. They also report deaths regardless of whether or not the consumer was receiving services when the death occurred.

Though not required, some providers voluntarily report all deaths of consumers to the Department regardless of cause or where the death occurs.

All deaths reported to the Department, regardless of whether or not reporting is required, are screened to determine if an investigation is warranted. The primary purpose of the screening and any subsequent investigation is to evaluate the cause of the death and any contributing factors, to determine if the death may have been preventable, and to ensure that the facility appropriately identifies and takes action to correct any deficiencies or to pursue opportunities for improvement that may exist in order to protect consumers and to prevent similar occurrences in the future. Deaths are also screened and investigated to determine if they were related to the use of physical restraint, physical hold, or seclusion.

As noted above, the number of deaths reported to the Department, and the focus of screening and investigation activities go beyond what is required to be included in this report.

For the purposes of this report, only content specified by state law is included: (a) deaths occurring within seven days of the use of physical restraint, physical hold, or seclusion or

resulting from violence, accident, suicide or homicide, and (b) investigation findings that indicate whether the death was related to the use of physical restraint, physical hold, or seclusion.

Table A provides a summary of the number of deaths (occurring within seven days of the use of physical restraint, physical hold or seclusion, or due to violence, accident, suicide, or homicide) reported during the state fiscal year by private licensed, private unlicensed, and state-operated facilities, the number of deaths investigated, and the number found by the investigation to be related to the facility's use of physical restraint, physical hold, or seclusion.

Tables A-1 through A-10 in Appendix A provide an expanded summary of the number of deaths reported by county and facility name.

Table A: Summary Data On Consumer Deaths Reported During SFY 2009-2010

Table in Appendix	Type of Facility	# Facilities Providing Services[1]	# Beds at Facilities[1]	# Facilities Reporting Deaths	# Death Reports Received & Screened[2]	# Death Reports Investigated[3]	# Deaths Related to Restraints / Seclusion[4]
PRIVATE LICENSED							
A-1	Assisted Living Facilities	1,241	40,081	31	36	31	0
A-2	Group Homes; Day & Outpatient Treatment	3,570	14,032	19	30	17	0
A-3	Community ICF-MRs	329	2,726	2	2	2	0
A-4	Psychiatric Hospitals, Units, & PRTFs	77	1,913	18	28	14	0
	Subtotal	5,217	58,752	70	96	64	0
PRIVATE UNLICENSED							
A-5	Private Unlicensed[5]			75	97	97	0
STATE OPERATED							
A-6	Alcohol and Drug Treatment Centers	3	215	1	1	1	0
A-7	Developmental Center (ICF-MR)	3	1,323	1	1	1	0
A-8	Neuro-Medical Treatment Centers	3	719	0	0	0	0
A-9	Psychiatric Hospitals	4	1,091	3	10	1	0
A-10	Residential Programs for Children	2	42	0	0	0	0
	Subtotal	15	3,390	5	12	3	0
	Grand Total	**5,232**	**62,142**	**150**	**205**	**164**	**0**

NOTES:

1. The number of facilities and beds can change during the year. The numbers shown are as of the end of the state fiscal year (June 30, 2010).
2. Numbers reflect only reportable deaths (occurring within seven days of physical restraint, physical hold, or seclusion, or the result of violence, accident, suicide, or homicide). All death reports were screened.
3. Deaths that occur within seven days of restraint/seclusion are required to be investigated. For other deaths, the decision to investigate and the level of investigation depends on the circumstances and information provided. Some investigations may be limited to confirming information or obtaining additional information.
4. Findings in this column indicate that restraint/seclusion either: (a) may have been a factor, but not necessarily the cause of death, or (b) may have resulted in the death.
5. The number of these facilities is unknown as they are not licensed or state-operated.

SUMMARY OF FINDINGS RELATED TO REPORTED DEATHS

As Table A shows:

- A total of 150 facilities -- 70 private licensed facilities, 75 private unlicensed facilities, and 5 state-operated facilities -- reported a total of 205 deaths that were subject to statutory reporting requirements.
- Of the total 205 deaths reported, 96 deaths were reported by private licensed facilities, 97 deaths were reported by private unlicensed facilities, and 12 deaths were reported by state-operated facilities.
- All deaths that were reported were screened. A total of 164 deaths (80%) were investigated.
- A total of 15 deaths that were reported occurred within seven days of the use of physical restraint, physical hold, or seclusion. However, none of these deaths were related to the use of these restrictive interventions.
- Overall, none of the deaths that were reported were found to be related to the use of physical restraint, physical hold, or seclusion.

PART B. FACILITY COMPLIANCE WITH LAWS, RULES, AND REGULATIONS GOVERNING THE USE OF PHYSICAL RESTRAINTS, PHYSICAL HOLD AND SECLUSION

Session Laws 2000-129 and 2003-80 also require the Department to report each year on the level of facility compliance with laws, rules, and regulations governing the use of physical restraints, physical hold, and seclusion to include areas of highest and lowest levels of compliance.

The compliance data summarized in this section was collected from on-site visits by Department staff for licensure surveys, follow-up visits, and complaint and death investigations during the state fiscal year beginning July 1, 2009 and ending June 30, 2010. Please note that Department staff did not visit all facilities. Therefore, the data summarized in this section is limited to those facilities that received an on-site visit by Department staff.

Table B provides a summary of the number of physical restraint, physical hold, and seclusion related citations that were issued to private licensed, private unlicensed, and state-operated facilities. The table shows the number of facilities that received a citation, the number of citations issued, and examples of the most frequent and least frequent citations issued.

Tables B-1 through B-10 in Appendix B provide an expanded summary of the number of citations issued by county and facility name.

Table B: Summary Data On Citations Related To Physical Restraint, Physical Hold, and Seclusion Issued During SFY 2009-2010[1]

Table in Appendix	Type of Facility	# Facilities Issued a Citation	# Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
PRIVATE LICENSED					
B-1	Assisted Living Facilities	9	14	• Inappropriate use of restraints (failure to obtain physician order, assessment, use least restrictive device, or no alternative attempted) (8 citations) • Inadequate assessment and care planning for the use of restraints (2 citations) • Failure to provide required staff training on the use of restraints (2 citations)	• Failure to obtain physician's order for use of restraint (1 citation) • Failure to maintain required documentation on the use of a restraint (1 citation)
B-2	Group Homes; Day & Outpatient Treatment	194	306	• Training on alternatives to restrictive interventions (147 citations). • Training in seclusion, physical restraint and isolation time-out (118 citations). • Least restrictive alternative	• Seclusion, physical restraint and isolation time-out (11 citations) • General policies (7 citations) • Prohibited procedures (3 citations) • Protective devices

Table in Appendix	Type of Facility	# Facilities Issued a Citation	# Citations Issued	Most Frequently Issued Citations	Least Frequently Issued Citations
				(19 citations)	(1 citation)
B-3	Community ICF-MRs	2	3	• Record of checks and usage must be kept (2 citations)	• Physical restraint must be an integral part of an individual program plan (1 citation)
B-4	Psychiatric Hospitals, Units, & PRTFs	17	35	• Use of restraint or seclusion must be in accordance with physician orders (16 citations) • Free from all forms of abuse or harassment (5 citations) • Orders must never be written as a standing order or as needed basis (5 citations) • Limits of orders up to 24 hours (3 citations)	• Right to be free from restraint or seclusion (1 citation) • Restraint or seclusion must be the least restrictive intervention (1 citation) • Use of restraint or seclusion in accordance with plan of care (1 citation)
	Subtotal	222	358		
PRIVATE UNLICENSED					
B-5	Private Unlicensed	0	0	• No citations were issued	• No citations were issued
STATE OPERATED					
B-6	Alcohol and Drug Treatment Center	0	0	• No citations were issued	• No citations were issued
B-7	Developmental Center (ICF-MR)	0	0	• No citations were issued	• No citations were issued
B-8	Neuro-Medical Treatment Center	0	0	• No citations were issued	• No citations were issued
B-9	Psychiatric Hospitals	1	2	• None in this category	• Implements in accordance with safe and appropriate techniques (1 citation) • Free from all forms of abuse or harassment (1 citation)
B-10	Residential Programs for Children	0	0	• No citations were issued	• No citations were issued
	Subtotal	1	2		
	Grand Total	**223**	**360**		

NOTES:

1. The citations summarized in this table do not reflect all facilities. The data is limited to those facilities that received an on-site visit by Department staff. Department staff conducted a total of 3,149 licensure surveys, 1,503 follow-up visits, and 1,117 complaint investigations during the year.

SUMMARY OF FINDINGS RELATED TO COMPLIANCE WITH LAWS, RULES, AND REGULATIONS

As Table B shows:

- A total of 223 facilities -- 222 private licensed facilities, no private unlicensed facilities, and one state-operated facility -- were cited for non-compliance with one or more rules governing the use of physical restraint, physical hold, or seclusion.
- It should be noted that the compliance data do not reflect all facilities. Rather, the data is limited to those facilities that warranted an on-site visit by Department staff. A total of 3,149 initial, renewal and change-of-ownership licensure surveys, 1,503 follow-up visits, and 1,117 complaint investigations were conducted during the year. Because of the potential for some facilities to have had more than one type of review, an exact unduplicated count of facilities reviewed is not available.
- A total of 360 citations were issued across all facility types for non-compliance with rules governing the use of physical restraint, physical hold, or seclusion. Private licensed facilities received 358 citations, private unlicensed facilities received no citations, and state-operated facilities received two citations. Citations covered a wide range of deficiencies from inadequate documentation and training to improper or inappropriate use of physical restraints.
- The largest number of citations issued involved deficiencies related to "training on alternatives to restrictive interventions" (147 or 41%), "training in seclusion, physical restraint and isolation time-out" (120 or 33%), and failure to use "least restrictive alternative" (20 or 6%). These citations accounted for 80% of the total issued.

APPENDIX A: CONSUMER DEATHS REPORTED BY COUNTY AND FACILITY

Tables A-1 through A-10 provide data for private licensed facilities, private unlicensed facilities, and state-operated facilities regarding deaths that occurred during the state fiscal year beginning July 1, 2009 and ending June 30, 2010 that were subject to the reporting requirements in G.S. 122C-31, 131D-10.6B and 131D-34.1, namely deaths that occurred within seven days of physical restraint, physical hold, or seclusion, or that were the result of violence, accident, suicide or homicide.

These tables do not include deaths that were reported to the Department for other reasons or that were the result of other causes. Each table represents a separate licensure category or type of facility. Each table lists by county, the name of the reporting facility, number of deaths reported, the number of death reports investigated, and the number investigated that were determined to be related to the use of physical restraint, physical hold, or seclusion.

It should be noted that all deaths that were reported were screened and investigated when circumstances warranted it. As the tables show, none of the deaths that were reported and investigated were found to be related to the use of physical restraints, physical hold, or seclusion.

Table A-1: Private Licensed Assisted Living Facilities[1]

County	Facility	# Deaths Reported and Screened	# Death Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Alamance	Ashley Family Care Home	1	1	0
	Clare Bridge at Burlington Manor	1	1	0
Bertie	Windsor House	1	1	0
Bladen	Cape Fear Manor	1	1	0
Burke	Longview Assisted Living	1	0	0
Caldwell	Carolina Oaks Enhanced Care Center	1	1	0
Catawba	Austin Adult Care	1	1	0
	Walden House	1	1	0
Chowan	Edenton House	1	0	0
Clay	Hayesville House	1	1	0
Davidson	Brookstone Retirement Center	1	1	0
Johnston	United Family Care, Inc.	1	1	0
Davie	Davie Place Residential	1	1	0
Durham	Carolina House of Durham	1	1	0
Forsyth	Forest Heights Senior Living Community	1	1	0
Guilford	Bennett's Family Care Home #2	1	1	0
	Loyalton of Greensboro	2	2	0
Harnett	Brookfield Retirement Center	2	1	0
Lincoln	Lakewood Care Center	1	1	0
McDowell	Cedarbrook Residential Center	1	1	0
Mecklenburg	Sunrise of South Charlotte	1	1	0
	Weddington Park	2	1	0
Montgomery	Poplar Springs	1	1	0
Moore	Magnolia Gardens	1	1	0
Onslow	The Arc Community	1	1	0
Robeson	Greystone Manor	2	2	0

County	Facility	# Deaths Reported and Screened	# Death Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Rowan	Britthaven of Kannapolis	2	2	0
Transylvania	Kings Bridge House	1	0	0
Wake	Aversboro Assisted Living of Garner, LLC	1	1	0
	Heartfield's at Cary	1	1	0
	Lawndale Manor	1	1	0
Total	31 Facilities Reporting	**36**	**31**	**0**

NOTES:

1. There were 1,241 Licensed Assisted Living Facilities with a total of 40,081 beds as of June 30, 2010.
2. For licensed assisted living facilities, the investigation is initiated by a referral of the death report to the Adult Care Licensure Section of DHSR and the County Department of Social Services by the DHSR Complaint Intake Unit after screening for compliance issues.
3. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-2: Private Group Homes, Day and Outpatient Treatment facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Buncombe	Western Carolina Treatment Center	1	1	0
Cabarrus	McLeod Addictive Disease Center	4	2	0
Catawba	McLeod Addictive Disease Center	1	0	0
Craven	PORT Human Services- New Bern MMP	1	1	0
Cumberland	Fayetteville Treatment Center	1	1	0
	Alternative Care Substance Abuse Services	1	0	0
Durham	Durham Treatment Center	1	0	0
	BAART Community Healthcare	1	0	0
Gaston	McLeod Addictive Disease Center	4	3	0
Iredell	McLeod Addictive Disease Center	1	1	0
McDowell	McLeod Addictive Disease Center	1	0	0
Mecklenburg	McLeod Addictive Disease Center	2	2	0
	Queen City Treatment Center	1	1	0
New Hanover	New Visions	1	0	0
	Coastal Horizons Center, Inc.	5	1	0
Polk	CooperRiis	1	1	0
Rowan	Rowan Treatment Associates	1	1	0
Union	McLeod Addictive Disease Center	1	1	0
Watauga	McLeod Addictive Disease Center	1	1	0
Total	19 Facilities Reporting	**30**	**17**	**0**

NOTES:

1. There were 3,570 Group Homes, Day and Outpatient Treatment Facilities with a total of 14,032 beds as of June 30, 2010.
2. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-3: Private Intermediate Care Facilities for the Mentally Retarded (ICF-MR)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Cabarrus[3]	RHA Howells CCC/Clearcreek	1	1	0
Iredell	UMAR-Weaver	1	1	0
Total	2 Facilities Reporting	**2**	**2**	**0**

NOTES:

1. There were 329 Private ICF-MR's with a total of 2,726 beds as of June 30, 2010.
2. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.
3. This death occurred in June 2009 but was not included in last year's report.

Table A-4: Private Psychiatric Hospitals, Inpatient Psychiatric Units, and Psychiatric Residential Treatment Facilities[1]

County	Facility	# Deaths Reported and Screened[2]	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Catawba	Catawba Valley Medical Center	3	0	0
Cleveland	Cleveland Regional Hospital	1	1	0
Craven	Craven Regional Hospital	1	1	0
Cumberland	Cape Fear Valley Medical Center	1	1	0
Durham	Duke University Hospital	1	1	0
Moore	FirstHealth Moore Regional	2	0	0
Gaston	Gaston Memorial Hospital	2	0	0
Mecklenburg	Carolinas Medical Center - Behavioral Health	2	1	0
Nash	Nash General Hospital	1	1	0
Orange	UNC Hospitals	3	1	0
Pitt	Pitt County Memorial Hospital	4	1	0
Rutherford	Rutherford Hospital	1	1	0
Stanly	Stanly Regional Medical Center	1	1	0
Wake	Holly Hills Hospital	1	0	0
	Duke Health Raleigh	1	1	0
	Rex Hospital	1	1	0
	Wake Med Raleigh	1	1	0
Watauga	Watauga Medical Center	1	1	0
Total	18 Facilities Reporting	**28**	**14**	**0**

NOTES:

1. There were 6 Private Psychiatric Hospitals, 43 Hospitals with Acute Care Psychiatric Units, and 28 Psychiatric Residential Treatment Facilities (PRTFs) with a total of 1,913 beds as of June 30, 2010.
2. Fourteen of these deaths occurred within seven days of the use of physical restraint, physical hold, or seclusion. However, none of these deaths were related to their use.
3. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-5: Private Unlicensed Facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Alleghany	New River Behavioral Healthcare	1	1	0
Ashe	New River Behavioral Healthcare	2	2	0
Avery	New River Behavioral Healthcare	2	2	0
Buncombe	Universal Mental Health Services	1	1	0
	ARP Phoenix	1	1	0
	Western NC Community Health Services	1	1	0
	RHA Behavioral Health Services	1	1	0
Cabarrus	Daymark Recovery Services	3	3	0
Caldwell	New River Behavioral Healthcare	1	1	0
Carteret	Onslow Carteret Behavioral Health	1	1	0
	Coastal Horizons Center	1	1	0
Catawba	CNC/ Access	1	1	0
Chatham	Therapeutic Alternatives	1	1	0
	Freedom House Recovery Center	1	1	0
Cleveland	True Behavioral Health	1	1	0
Columbus	Evergreen Behavioral	1	1	0
Craven	RHA Behavioral Health Services	1	1	0
	PORT Human Services	1	1	0
Durham	Family Presevation Services	1	1	0
	Easter Seals UCP of NC	1	1	0
Forsyth	Daymark Recovery Services	4	4	0
	Partnership for Drug Free NC	1	1	0
	Triumph, LLC	1	1	0
	The Childrens Home	1	1	0
Gaston	Self concepts	1	1	0
	Greater Metrolina Mental Health	1	1	0
	Family Works, Inc	1	1	0
	True Behavioral Healthcare, INC	1	1	0
	Cornerstone Christian Center	1	1	0
Guilford	Partnership for Drug Free NC	1	1	0
	Envisions of life	1	1	0
	RHA Behavioral Health Services	1	1	0
	Shepherd House Apartments	1	1	0
	Adult Day & Respite Care Center	1	1	0
Haywood	Meridian Behavioral Health Services	3	3	0
	Smoky Mountain Center	1	1	0
	Meridian Behavioral Health Services	1	1	0
Hoke	Daymark Recovery Services	1	1	0
Jackson	Meridian Behavioral Health Services	1	1	0
Lenoir	PORT Human Services	1	1	0
	Coastal Horizons Center	1	1	0
McDowell	Strategic Interventions	1	1	0
Mecklenburg	Mecklenburg Open Door	1	1	0

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
	Community Support			
Moore	Partnership for Drug Free NC	1	1	0
Nash	Port Human Services	2	2	0
	LeChris Health Center	1	1	0
Onslow	Onslow Carteret Behavioral Health	3	3	0
	Coastal Horizons Center	1	1	0
	Access Behavioral Assistance	1	1	0
	IQuOLIOC Inc	1	1	0
Orange	UNC STEP Clinic	1	1	0
Pasquotank	Benjamin House Inc	1	1	0
Person	Carolina Behavioral/Triumph	1	1	0
Pitt	Eastern Carolina Case Management	1	1	0
Robeson	Crossroads Associates	1	1	0
	Evergreen Behavioral	1	1	0
Rockingham	Daymark Recovery Services	1	1	0
Rowan	Partnership for Drug Free NC	1	1	0
Rutherford	Family Preservation Services	1	1	0
	Parkway Behavioral Health	2	2	0
Stanly	Daymark Recovery Services	3	3	0
	Stanly/Kannapolis ACTT	1	1	0
Surry	Easter Seals United Cerebral Palsy	2	2	0
	New River Behavioral Healthcare	1	1	0
Union	Daymark Recovery Services	5	5	0
Wake	Wake County Human Services	2	2	0
	Fellowship Health Resources	1	1	0
	Quality Care Solutions, Inc.	1	1	0
	Psych Support, Inc	1	1	0
Washington	APlus Results	1	1	0
Watauga	Watauga Recovery Education Center	1	1	0
	New River Behavioral Health	1	1	0
Wayne	Coastal Horizons Center	1	1	0
Wilkes	New River Behavioral Health	2	2	0
Yancey	Alpha Omega Health	1	1	0
Total	75 Facilities Reporting	**97**	**97**	**0**

NOTES:

1. The number of these facilities is unknown as they are not licensed or state-operated.
2. All of the deaths annotated in this column were investigated by the responsible Local Management Entity (LME) providing oversight, and the findings were reviewed by the Division of MH/DD/SAS.
3. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-6: State Alcohol and Drug Abuse Treatment Centers (ADATC)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Granville	R. J. Blackley	1	1	0
Total	1 Facility Reporting	**1**	**1**	**0**

NOTES:

1. There were 3 State-Operated Alcohol and Drug Abuse Treatment Centers with a total of 215 beds as of June 30, 2010.
2. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death

Table A-7: State Intermediate Care Facilities for the Mentally Retarded (ICF-MR)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
Burke	J. Iverson Riddle	1	1	0
Total	1 Facility Reporting	**1**	**1**	**0**

NOTES:

1. There were 3 State-Operated ICF-MR's with a total of 1,323 beds as of June 30, 2010.
2. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-8: State Neuro-Medical Treatment Center[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
	No deaths were reported	0	0	0
Total	0 Facilities Reporting	**0**	**0**	**0**

NOTES:

1. There were 3 State-Operated Neuro-Medical Treatment Centers with a total of 719 beds as of June 30, 2010.
2. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-9: State Psychiatric Hospitals[1]

County	Facility	# Deaths Reported and Screened[2]	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[3]
Burke	Broughton	4	0	0
Granville	Central Regional	3	0	0
Wayne	Cherry	3	1	0
Total	3 Facilities Reporting	**10**	**1**	**0**

NOTES:

1. There were 4 State-Operated Psychiatric Hospitals with a total of 1,091 beds as of June 30, 2010.
2. One death occurred within seven days of the use of physical restraint, physical hold, or seclusion. However, this death was not related to its use.
3. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

Table A-10: State Residential Program For Children[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Deaths Related to Restraints/ Physical Hold/ Seclusion[2]
	No deaths were reported	0	0	0
Total	0 Facilities Reporting	**0**	**0**	**0**

NOTES:

1. There were 2 State-Operated Residential Programs For Children with a total of 42 beds as of June 30, 2010.
2. Findings in this column indicate that restraint/seclusion either (1) may have been a factor, but not necessarily the cause of death, or (2) may have resulted in the death.

APPENDIX B: NUMBER OF CITATIONS RELATED TO PHYSICAL RESTRAINT, PHYSICAL HOLD, AND SECLUSION BY COUNTY AND FACILITY

Tables B-1 through B-10 provide data regarding the number of physical restraint, physical hold, and seclusion related citations that were issued to private licensed, private unlicensed, and state operated facilities during the state fiscal year beginning July 1, 2009 and ending June 30, 2010. Each table represents a separate licensure category or type of facility. Each table shows by county the name of facilities that received a citation, and the number of citations issued.

The compliance data summarized in this section was collected from on-site visits conducted by Department staff for initial, renewal and change-of-ownership licensure surveys, follow-up visits and complaint investigations. Please note that Department staff did not visit all facilities. Therefore, the data summarized in this section is limited to those facilities that received an on-site visit by Department staff. A total of 3,149 licensure surveys, 1,503 follow-up visits, and 1,117 complaint investigations were conducted during the year. An exact number of facilities reviewed can not be readily determined as some facilities may have had more than one type of review.

Table B-1: Private Licensed Assisted Living Facilities

County	Facility	# Citations
Buncombe	Hominy Valley Retirement Center	3
Caldwell	The Shaire Center	2
Columbus	Lake Pointe Assisted Living	1
Halifax	Carolina Rest Home	1
Henderson	Cardinal Care of Hendersonville	1
Martin	Vintage Inn	1
New Hanover	Hermitage House Rest Home	1
Orange	Crescent Green of Carrboro	2
Rutherford	Hillcrest Rest Home	2
Total	9 Facilities Cited	**14**

Table B-2: Private Group Homes, Day and Outpatient Treatment Facilities

County	Facility	# Citations
Alamance	A Solid Foundation	2
	Just In Time	2
	Never Give Up Community Sv	1
	New Dimensions Interventions A	2
	New Dimensions Interventions B	2
	Safe Haven House	1
	Sixth Street DDA Group Home	2
	Union Avenue Group Home	2
	United Care Center	2
	United Care Center #2	2
Alexander	Peace Haven Group Home	1
Avery	Avery County Group Home	1
	Grandfather Home for Children	1
Beaufort	Excel for Life	1
Bertie	Rayann	1

County	Facility	# Citations
Brunswick	Birges Home	2
Buncombe	1st Step Farm - Men's	2
	1st Step Farm - Women's	2
	Carolina Mountain DDA Group Home	1
	Castlerock	2
	Dignity Enterprises	1
	Dos Porticos en el Sol	2
	First at Blue Ridge	1
	Marne	1
Burke	Flynn Christian Fellowship Home	1
Cabarrus	Cabarrus County Group Home	1
	Serenity House	1
Caldwell	A New Dimension SA Counseling Service	1
	Caldwell Opportunities	1
	New River Behavioral Healthcare - Lenior	1
	VOCA- ELM	1
Catawba	Blevins House	2
	Boyd Corner House II	2
Chatham	Gray Alternative Care Group Home	2
Clay	Mountain Vineyard Home	1
Cleveland	Charlespointe	1
Columbus	New Opportunities of Columbus Co.	1
Cumberland	Ashton W. Lilly Home	1
	Carol's DDA Group Home	2
	Forever Young Group Home II	2
	Luv-N-Arms	1
	Murray Fork Group Home	1
	Patterson Home Inc	1
	Rainbow of Sunshine	2
	Stepping Stone	1
	T&S Group Home II	2
	United Residential Svc of NC	1
	Visions McArthur Road	4
	Woodbridge Alt. at Stonykirk	1
Davidson	Davidson House	2
	Southmont Home	1
Davie	Emmanuel House	2
Duplin	Tri-County Youth Services	1
	White Oak Group Home XI	2
	White Oak Group Home XIV	1
Durham	BAART Community Healthcare	2
	Comprehensive Community Care	1
	DHD Group Home	2
	Graves Group Home	4
	Greater Faith Home Care	2
	Joyland Homes Inc	1
	Peaceful House II	2
	Rose's Castle Residential Svc. Inc	1
	TROSA (female)	2
	TROSA (male)	2
Edgecombe	Daystar Residential Program	1
Forsyth	Aldersgate	2

County	Facility	# Citations
	Ansley Home	2
Forsyth	Echo Trail	3
	Eldorada	1
	Emmanuel House	2
	Group Homes of Forsyth - Brandywine	1
	Group Homes of Forsyth - Pressman	1
	Jones Caring Services	2
	King-Wendt home	1
	Linville Place	2
	MODA Suman Services #1	2
	Oliver Christian Home	1
	Salem House	2
Franklin	E.W. Stone Adult Care Center	2
	Eason Court	2
	Eason Court #2	2
Gaston	Monument Home	1
Guilford	Achievement Place	1
	Alcoholic's Home, Inc. -House of Prayer	1
	Angelic Heartz	1
	Brentwood	1
	CC&A Community Services, Inc.	4
	CC&A Family Services #2	2
	Classic Care Family Services	2
	Coltrane's Group Home	2
	Darden Home	1
	Lanier Home	2
	Linsher Cares	1
	Northwest House	1
	Peguese Home	2
	Precious Pearls Group Home	1
	RJ Whitsett Residential Services 1	2
	RJ Whitsett Residential Services 2	2
	Safe Haven Home, LLC	1
	Specialized Home Care & Redevelopment	4
	Step Down Group Home	2
	Successful Transitions I	1
	Sylvanglade Home	1
	Triad Centers for Youth, Inc.	2
	Youthful Image, Inc II	2
Harnett	PALS West J	1
	Professional Family Care Home #4	2
	Professional Family Care Home #5	4
Henderson	Health Care Solutions Network	1
Hoke	Lend a Helping Hand	1
	McEachern Treatment Facility	1
	Shalom Residential	1
Johnston	Unity Residential Services (051-171)	2
	Johnston Co. Group #2	1
	Johnston Co. Group #3	1
	Lane Home	2
	Savin Grace II	1
	Unity Residential Services (051-149)	2

County	Facility	# Citations
Lenoir	Kristi's Home Inc	2
Lenoir	Oakwood Facility	8
	Pinewood	2
Lincoln	Jaclyn	1
Martin	South Harrell Street Residential	1
McDowell	East Court Group Care	1
	MH Professionals	1
	Recovery Ventures Corporation	3
Mecklenburg	Blair Road	1
	Echelon 3	2
	Echelon 4	2
	Ernestine Johnson	1
	One Step Forward	1
	Promise Keepers	1
	The Keys of Carolina	8
	TRC's Day Treatment Program	1
Nash	Carolina Humana	1
	My Guardian Angel	1
New Hanover	Cape Fear Respite	1
	Faith House	2
	Market Street	1
	New Directions Home	2
Onslow	McIver Home	2
	Moore Home	1
Orange	Sunrise Casaworks	1
Person	McDaniel #2	1
	McDaniel #3	1
Pitt	Divine Guidance Integrative Svc. Inc	1
	Divine Guidance Integrative Svc. Inc #3	2
	Evans Home	2
	Mitchell & Crandell Family Svc.	1
Randolph	Alpha House	2
Robeson	Future Innovations	1
	Peace of Mind Res. & Community Svc #2	1
	Robeson County GH	1
	The Rossberry Home of Fairmont	2
Rockingham	Remmsco Men's Halfway House	2
	Remmsco Women's Halfway House	2
Rowan	House of Sharon	2
	New Hope Residential Services	2
Rutherfordton	Joyful Too!	1
Sampson	Whitfield Homes ASP II	2
Transylvania	Trails of Carolina	3
Union	Behavioral Health First Step	1
	Elizabeth House	2
	Griffith Road Home	1
Wake	Absolute Home	1
	Azalea Gardens MH Facility	2
	Canaan Care Home #1	1
	Canaan Care Home #2	1
	Coleman Health Facility	1
	Facing the Future	1

County	Facility	# Citations
	Kirby Falls	1
Wake	McNeill Home #2	2
	Novella's Place	1
	Reaching Your Goals #1	1
	Sandlewood Drive Home	1
	The Rosalie Foundation	1
	Woodard's Place	1
Warren	Bynum's Place	2
	Wortham's GH LLC	2
Wayne	Daez of New Visions	1
	Estes Easy Living Home	1
	Flynn Home	1
	Gully Street	1
	Harbor House	1
	Harbor House VII	2
	Howell & Howell	2
	Living in Hope	1
	Mar-Mac	1
	The John Oliver Center	1
Wilkes	268 Home	1
Wilson	Dunn's House of Love	1
	MADIP Homes	2
	Wellman Center #3	1
Total	194 Facilities Cited	**306**

Table B-3: Private Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

County	Facility	# Citations
Guilford	Voca-Meadowood Group Home	1
Wake	Helmsdale Group Home	2
Total	2 Facilities Cited	**3**

Table B-4: Private Psychiatric Hospitals, Inpatient Psychiatric Units, and Psychiatric Residential Treatment Facilities

County	Facility	# Citations
Alamance	Alamance Regional Hospital	1
Beaufort	Beaufort Medical Center	1
Durham	Duke Medical Center	2
Duplin	Duplin General Hospital	2
Forsyth	Select Specialty Hospital	1
Gaston	Gaston Memorial	2
Guilford	The Moses H. Cone	5
Henderson	Park Ridge Medical Center	1
Nash	Nash General Hospital	3
	Life Care	2
Onslow	Onslow Memorial Hospital	1
Orange	UNC Hospital	3
Richmond	Sandhills Regional Hospital	5
Rutherford	Rutherford Memorial Hospital	1

Stanly	Stanly Regional Medical Center	3
Wake	Holly Hills	1
Wilson	Wilson Memorial Hospital	1
Total	17 Facilities Cited	**35**

Table B-5: Private Unlicensed Facilities:

County	Facility	# Citations
	No citations were issued	0
Total	0 Facilities Cited	**0**

Table B-6: State Alcohol and Drug Abuse Treatment Centers (ADATC)

County	Facility	# Citations
	No citations were issued	0
Total	0 Facilities Cited	**0**

Table B-7: State Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

County	Facility	# Citations
	No citations were issued	0
Total	0 Facilities Cited	**0**

Table B-8: State Neuro-Medical Treatment Center

County	Facility	# Citations
	No citations were issued	0
Total	0 Facilities Cited	**0**

Table B-9: State Psychiatric Hospitals

County	Facility	# Citations
Wayne	Cherry Hospital	2
Total	1 Facility Cited	**2**

Table B-10: State Residential Program For Children

County	Facility	# Citations
	No citations were issued	0
Total	0 Facilities Cited	**0**